OAH 8-0900-22337-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Frazee Care Center **RECOMMENDED DECISION**

The above matter came before Administrative Law Judge Eric L. Lipman for an informal dispute resolution meeting on November 10, 2011. The meeting concluded on that date.

Christine R. Campbell, Northeastern District Office, appeared on behalf of the Minnesota Department of Health ("the Department"). Mary Cahill also attended the meeting and made comments on behalf of the Department.

Austin Blilie, Administrator of the Frazee Care Center, appeared on behalf of the Frazee Care Center ("the facility"). Joining him and making presentations at the meeting were Randi Hanson, R.N., and Donna Galbrecht, R.N.

Based upon the submissions of the parties at the resolution meeting and the contents of the record, the Administrative Law Judge makes the following:

**RECOMMENDED DECISION**

(a) The Commissioner should further recommend that Tag F-323 be AFFIRMED; and,

(b) The Commissioner should further recommend that Tag F-373 be AFFIRMED.

Dated: November 29, 2011

s/Eric L. Lipman

ERIC L. LIPMAN
Administrative Law Judge

Reported: Digital recording, no transcript prepared

## NOTICE

Under Minn. Stat. § 144A.10, subdivision 16 (d) (6), this recommended decision is not binding upon the Commissioner of Health. Further, pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within 10 calendar days of receipt of this recommended decision.

## MEMORANDUM

This matter arises out of a state compliance survey conducted at the Frazee Care Center between June 6 and 13, 2011.

The Frazee Care Center, founded in 1974, is 74-bed nursing home facility in Frazee, Minnesota. The facility is an important resource for the surrounding community. It is both a place in which older residents can receive high quality care and where local health care professionals can be a part of rewarding and important work. On the basis of recent surveys from the Centers on Medicare and Medicaid Services (CMS), the facility's quality of care has been highly-rated.[1]

The Minnesota Department of Health ("MDH") issued a Statement of Deficiencies for the survey that ended on June 13, 2011. The statement designated a series of "F-Tags." These tags set forth areas in which the Department asserts that the Frazee Care Center fell below the federal requirements for participation in the Medicare and Medicaid programs.[2] If sustained, either or both of these deficiencies could result in the application of sanctions to the facility.

### General Statutory and Regulatory Background

Participation requirements for skilled nursing and other long-term care facilities in the Medicare program are set forth in 42 C.F.R. Part 483, Subpart B. Provisions governing the surveying of long-term care facilities and enforcement of their compliance with participation requirements are in 42 C.F.R. Part 488, Subparts E and F.

Federal Medicare and Medicaid authorities assure compliance with the participation requirements through regular surveys by state agencies. The survey agency reports any "deficiencies" on a standard form called a "Statement of Deficiencies."[3]

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[1] *See*, Testimony of Austin Blilie.

[2] *See*, 42 C.F.R. § 488.325 (a); 42 C.F.R. § 488.301; MDH Ex. C (CMS State Operations Manual, Appendix P, Section IV).

[3] *See, e.g.,* MDH Exhibit F.

A "deficiency" is a failure to a meet a participation requirement in 42 C.F.R. Part 483.[4] Deficiency findings are organized in the Statement of Deficiencies under alpha-numeric "tags," with each tag corresponding to a regulatory requirement in Part 483.[5] The facts alleged under each tag may include a number of survey findings, which (if upheld) would support the conclusion that a facility failed to meet the regulatory standards.

A survey agency's findings also include a determination as to the "seriousness" of each deficiency.[6] The seriousness of a deficiency depends upon both its "scope" and its "severity."[7]

When citing deficiencies, state surveyors use the CMS Guidance on Deficiency Categorization. The range of deficiencies is set out on three-column, four-level grid. Each square on the Grid has a letter designation. "A" is the least serious and "L" is the most serious. The fourth level of the grid (including designations J, K and L) is reserved for those deficiencies which place residents in immediate jeopardy.[8]

A facility becomes subject to remedial action under the participation agreement when it is not in "substantial compliance" with one or more regulatory standards.[9] A facility is not in substantial compliance with a participation requirement if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[10]

If a facility is found not to be in "substantial compliance," CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiencies pursuant to a plan of correction.[11] Further, CMS may, based upon the severity of the deficiencies, impose an intermediate remedy, such as a monetary penalty, for each day in which the facility was not in substantial compliance with the terms of the participation agreement.[12]

Lastly, Minnesota Statutes § 144A.10, Subdivision 16, establishes a process for independent and informal resolution of disputes between survey agencies and health

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[4] *See*, 42 C.F.R. § 488.301.

[5] CMS State Operations Manual, Appendix PP, Section IV.

[6] *See*, 42 C.F.R. § 488.404.

[7] MDH Ex. C at C-1.

[8] *Id*.

[9] *See,* 42 C.F.R. § 488.400.

[10] *See,* 42 C.F.R. § 488.301.

[11] *See,* 42 C.F.R. §§ 488.402, 488.406 and 488.412.

[12] *See,* 42 C.F.R. §§ 488.406, 488.408 and 488.440.

care providers with a participation agreement. In this request for Independent Informal Dispute Resolution, the Frazee Care Center submits two F-Tags for review.

**Tag 323 – Accident Hazards**

### A. Regulatory Standards and the Surveyor Claims

Under the quality of care regulations, the facility must ensure that "(1) the resident environment remains as free from accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents."[13]

In its interpretative guidance, CMS has accorded the term "accident" an expansive definition, including a wide range of unanticipated events. "Accident" refers to "any unexpected or unintentional incident, which may result in injury or illness to a resident" and that does not follow from needed treatment or care.[14] Likewise important, "avoidable accident" is defined as "an accident occurred because the facility failed to … identify environmental hazards and individual resident risk of an accident, including the need for supervision … or … implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident …."[15]

While acknowledging that not all accidents are avoidable, the official guidance aims to prompt facilities to identify potential hazards, make interventions to reduce the risk of accidents and to modify prevention approaches when necessary.[16]

### B. Resident 80

Resident 80 suffers from a traumatic brain injury and was admitted to the Frazee Care Center November 30, 2010, following a 20-day hospital stay. At the time of his admission, it was noted that this resident has bouts of confusion and he was identified as an elopement risk.[17]

On December 23, 2010, Resident 80 had opened an alarmed door in the center's dining hall and attempted to make his way into the adjoining courtyard. Facility staff prevented the elopement and safely returned the resident to the facility.[18]

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[13] *See,* 42 C.F.R. § 483.25 (h).

[14] *See,* MDH Ex. G at G-1 (CMS State Operations Manual, Appendix PP, Section § 483.25 (h) (Accidents)).

[15] *Id.* at G-1 and G-2.

[16] MDH Ex. G at G-4 and G-5.

[17] MDH Ex. Q at Q-2, Q-6, Q-12, Q-16 and Q-17; Facility Statement at 1; Testimony of Randi Hanson

[18] Test. of R. Hanson.

On May 10, 2011, at approximately 2:00 p.m., a staff member observed Resident 80 unattended and outside, sitting in his wheelchair, approximately 20 feet from the facility. At the time that he was spotted by facility staff, Resident 80 was seated approximately 105 feet from the facility parking lot.[19]

As of May 10, the facility, believing that it was a requirement of the state fire code, had posted small placards above the key pads for each alarmed door. The placards, printed in a cursive font, read: "Emergency exit only. Enter code: one, two, three, four #". On that date, entering the numeric code 1, 2, 3, 4 and pressing the pound key (#) would de-activate the door alarm. Each alarmed door of the facility, except one, used this same de-activation code.[20]

Facility staff acknowledges that if a resident knows the alarm de-activation code, and is agile enough to enter the code and pass through the door within 15 seconds, the resident could elope from the facility undetected.[21]

Concluding that Resident 80 had read and understood the cursive writing, the care team reviewing the May 10 incident decided to remove the small placards above the alarm key pads. However, one of the placards, above the key pad at the front door of the facility was not removed, and it was in place during the state survey a month later. Likewise important, facility staff did not change the numeric codes on the alarm system following the elopement of Resident 80.[22]

On May 24, 2011, Resident 80 undertook another attempt to make his way out of the facility through the staff dining room, but was prevented from exiting the facility.[23]

On June 2, 2011, Resident 80 triggered the alarm on the front door of the facility. According to a nurse's note, Resident 80 successfully exited the facility before being returned by staff. Facility staff disputes this account – asserting that Resident 80's "Wanderguard" wrist bracelet triggers the front door alarm if Resident steps within a few feet of the front door. Staff asserts that Resident 80 was chatting with the front desk receptionist, and not attempting to elope, when the front door alarm sounded.[24]

When interviewed a few days later by a state surveyor about his elopements, Resident 80 was able to recount the alarm pass code to the surveyor.[25]

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[19] MDH Ex. F at F-51; Ex. Q at Q-23; Test. of R. Hanson; Facility Photographs 7 through 9 and 11 through 13.

[20] MDH Ex. F at F-52, F-53 and F-55; Facility Ex. A-18.

[21] MDH Ex. F at F-52.

[22] MDH Ex. F at F-53; MDH Ex. Q at Q-1.

[23] MDH Ex. F at F-51; MDH Ex. Q at Q-25.

[24] *Compare,* MDH Ex. Q at Q-25 with Facility Photograph 14 and Test. of R. Hanson.

[25] MDH Ex. F at F-53.

In the view of the Administrative Law Judge the key point in the record is not whether Resident 80 was able to make it out of the facility on June 2, 2011. Rather, in this circumstance, the quality of the facility's evaluations around elopement risk and the efficacy of its interventions, are far more important. In the view of the Administrative Law Judge, the belief that none of residents could understand cursive writing on placards above the alarm key pads points to a failure of evaluating the risks of elopement. Additionally, the failure to change alarm codes, or retrieve all of the publicly-accessible placards containing these codes, after Resident 80 successfully disabled the alarm and eloped, equals a failure to implement needed interventions.[26]

In similar circumstances, where the security codes needed to disable door alarms were accessible to facility residents, the Department of Health and Human Services' Departmental Appeals Board has upheld the surveyors' "immediate jeopardy" determinations and the imposition of weighty sanctions.[27]

The Commissioner should recommend that Tag F-323 be affirmed.

**Tag F-373 – Use of Paid Feeding Assistants**

At the Frazee Care Center, heath care professionals work as part of a team at meal times – with both Paid Feeding Assistants and at least one registered nurse on duty in the resident dining hall. The registered nurse directly supervises the feeding assistants and is available to render care in the event that a patient has a problem.[28]

**A. Regulatory Standards and Surveyor Claims**

Federal regulations govern the use of Paid Feeding Assistants. Paid Feeding Assistants are health care workers who have state-approved training, but less than professional credentialing.[29] These workers aid residents in eating at meal time.

The regulations provide that "facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems." Under the federal standards, "complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings."[30]

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[26] *Compare,* MDH Ex. E at E-5 with *MS Care Center of Greenville v. Centers for Medicare & Medicaid,* Docket No. C-10-913 (Dep't App. Bd. 2011) (http://www.hhs.gov/dab/decisions/civildecisions/cr2439.pdf); *Life Care Center of La Center v. Centers for Medicare & Medicaid*, Docket No. C-10-106 (Dep't App. Bd. 2011) (http://www.hhs.gov/dab/decisions/civildecisions/cr2361.pdf); *Lee County Care and Rehabilitation Center v. Centers for Medicare and Medicaid Services*, Docket No. C-09-526 (Dep't App. Bd. 2010) (http://www.hhs.gov/dab/decisions/civildecisions/cr2282.pdf).

[27] *Id.*

[28] *See,* Test. of R. Hanson; Facility Statement at 2.

[29] *See,* 42 C.F.R. § 483.35 (h); *see also*, Facility Ex. B-2.

[30] *See,* 42 C.F.R. § 483.35 (h)(3).

### B. Residents 6, 18, 21, 31 and 37

During the state survey in June of 2011, the surveyors identified five residents – Residents 6, 18, 21, 31 and 37 – whom they characterized as having complicated feeding problems, as those terms are used in 42 C.F.R. § 483.35 (h)(3). Four of these residents suffered from both dysphagia (a swallowing disorder that impedes movement of food from the mouth to the stomach) and upper respiratory problems.[31] A fifth resident, Resident 21, was earlier assessed as having problems with choking.[32] The Department argues that the regulations forbid the use of Paid Feeding Assistants with such patients.[33]

Although the facility discontinued its use of Paid Feeding Assistants following the declaration of "immediate jeopardy," it asserts that this determination was too severe and unwarranted. The facility argues that not only were one or more registered nurses present in the dining hall whenever these residents were eating, because the facility made the right choices as to the features of these residents' diet, no choking or aspiration occurred.[34]

Perhaps because F-373 is a fairly recent addition to the State Operations Manual,[35] the Departmental Appeals Board has no reported cases to guide the decision in this case. Yet, because Residents 6, 18, 21, 31 and 37 were on modified diets, and each had a care plan to address problems swallowing, the facility should have been aware that these residents could not receive the aid of Paid Feeding Assistants. Given the evident purpose of 42 C.F.R. § 483.35 (h)(3), the facility's violation of those eligibility standards is "a situation in which the provider's noncompliance … is likely to cause, serious injury, harm, [or] impairment … to a resident."[36]

The Commissioner should recommend that Tag F-373 be affirmed.

**E. L. L.**

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[31] *See,* MDH Ex. R at R-5, R-6 and R-12; MDH Ex. S at S-3 and S-8; MDH Ex. T at T-5 and T-9; MDH Ex. U at U-2 and U-3.

[32] MDH Ex. V at V-2.

[33] Testimony of Christine Campbell.

[34] *See,* Test. of R. Hanson; Facility Statement at 2.

[35] *See,* CMS Manual System, U.S. Department of Health & Human Services, Pub. 100-07, Transmittal 26 (August 17, 2007) (Revised Appendix P and Appendix PP – New Tag F373).

[36] *See,* 42 C.F.R. § 489.3 ("Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident").